

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-027249

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3662

FILED AUG 2 1962

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY JACKSON		a. STATE KANSAS b. COUNTY JOHNSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		c. CITY OR TOWN PRAIRIE VILLAGE	
Length of stay in 1b 3 DAYS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LUKE'S HOSPITAL		d. STREET ADDRESS (If outside, give location) 8420 CEDAR	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Middle Last JULIUS MASEDA		Month Day Year JULY 11 1962	
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2/13/20
9. AGE (last birthday) 42		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CO-OWNER-TOON SHOP		10b. KIND OF BUSINESS OR INDUSTRY PRAIRIE VILLAGE SHOPPING CENTER	
11. BIRTHPLACE (City and state or country) MEADOWBROOK, W. V.		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13a. FATHER'S NAME Cesar MASEDA		13b. MOTHER'S MAIDEN NAME Teresa Diaz	
14. NAME OF HUSBAND OR WIFE Mary Elizabeth Maseda		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes World War II	
16. SOCIAL SECURITY NO. [REDACTED]		17. INFORMANT Mary Elizabeth Maseda, 8420 Cedar Prairie Vill	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Gastrointestinal Hemorrhage</i> DUE TO (b) <i>Thrombocytopenia</i> DUE TO (c) <i>Dental Myelogenous Leukemia</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <i>March 1961</i> to <i>7-11-62</i> and last saw him alive on <i>7-10-62</i> Death occurred at <i>7:20 A.M.</i> on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <i>G. K. Skillman M.D.</i>	
22b. ADDRESS <i>Kansas City, Mo. 140</i>		22c. DATE SIGNED <i>7-11-62</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE July 13, '62	
23c. NAME OF CEMETERY OR CREMATORY Johnson County Mem. Gar.		23d. LOCATION (City, town, or county) Johnson County Kansas	
24. FUNERAL DIRECTOR D.W. NEWCOMER'S SONS KANSAS CITY, MO.		25. DATE RECD. BY LOCAL REG. 7-13-62	
26. REGISTRAR'S SIGNATURE <i>Ruth H. Long</i>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

INSTEAD OF

DATE AMENDED

USE BLACK INK
OR
TYPEWRITER RIBBONVS 300
Rev. 4/59

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Herold B. C. Sternacht

Licensed Embalmer, No. 3035

P. O. Address H. C. Stinson

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.